Department of Veterans Affairs **VHA DIRECTIVE 2003-041**
Veterans Health Administration
Washington, DC 20420 **July 29, 2003**

THIRD-PARTY REIMBURSEMENT UTILIZATION REVIEW

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes standardized guidance for the Utilization (UR) Review functions with third-party reimbursement responsibilities at VA medical centers.

2. BACKGROUND

a. UR operates to promote improvements in patient care and maximize potential for the recovery of funds due VA for the provision of health care services to veterans, dependents, and others using the VA health care system. VHA received the authority through Public Law 99-272, to seek reimbursement from third-party health insurers for medical care provided by the VA to insured veterans for non-service connected treatment.

b. UR review, from a payer's perspective, is a regulatory approach designed to control health care costs and meet the payer's objectives, which includes maximizing revenue and minimizing expenditures. Many payers (i.e., insurance companies) have become fiscal intermediaries for the Federal government, providing quality assurance, administrative services, and handling claims and payments for Medicare beneficiaries; as a result, they have adopted Medicare regulatory guidelines within their private insurance subsidiaries.

c. Overall, UR has become an increasingly prominent tool for containing cost and servicing government programs. Insurance companies, health maintenance organizations, hospitals, and other providers of health care services continue to implement UR strategies. Insurance companies employ registered nurses (RNs), physicians, and other clinicians to conduct aggressive UR clinical activities, questioning appropriateness and medical necessity, and monitoring medical decisions for conformance with known standards of practice and quality care.

d. Within the health care industry, the physician or provider of medical services is recognized as the key figure in determining utilization of health care services. The provider is responsible for justifying and documenting medical need for services and for obtaining medical necessity certification for the service(s) in order to receive adequate reimbursement. In the private sector, adequate reimbursement is one impetus that ensures adherence to medical review guidelines.

e. VHA has recognized the need to employ cost containment measures that include mandated UR programs to ensure appropriateness of care, and procedures to ensure adequate reimbursement for services. However, it has taken longer for these measures to be effective in VHA, due to VHA's mission, which is to function primarily as a service organization rather than as a for-profit organization. Today, VHA is recognized as a leader in implementing the technology necessary to support efficient and quality health care and to ensure an integrated health care delivery system for the veteran population.

THIS VHA DIRECTIVE EXPIRES JULY 31, 2008

f. With the broad array of health plans constantly changing, staff performing UR functions must serve as the critical link among clinicians, staff, patients, administration, and insurance companies. Staff performing UR functions for third-party reimbursement provide the clinical expertise and leadership for the implementation of a medical center's reimbursement program. This may entail working with all staff involved in the business cycle, and with other administrative and clinical staff of the medical center, to adopt new strategies on maximizing collections from third-party insurers. It is in this context that UR has become an essential core component within the VA business cycle.

3. POLICY: It is VHA policy that UR functions with third-party reimbursement are established at each VA medical center.

4. ACTION

a. **VISN Director.** The VISN Director is responsible for:

(1) Ensuring that each VA medical Center has UR for third-party reimbursement, optimally aligned within the Business Office (or equivalent).

(2) Ensuring that UR reviewers support the standardization of all UR activities associated with core business cycle functions.

NOTE: *UR positions require advanced clinical knowledge, communication skills and management abilities. Therefore, RNs appointed under Title 38 United States Code (U.S.C.) are responsible for performing the clinical UR activities for third party reimbursement. Present employees who are not RN, in these positions will be grand-fathered in, until their position becomes vacant.*

b. **Medical Center Director.** The Medical Center Director is responsible for:

(1) Ensuring the supervision and performance ratings for the UR nurse are conducted utilizing the VA Nurse Qualification Standard, VA Directive 5102.1, which includes nine dimensions of performance requirements for the appropriate Nurse II or Nurse III level of practice.

(2) Affording staff the educational and informational opportunities required to perform their assigned duties and assigning administrative support necessary for acquisition of tools and resources required for UR nurses to perform their assigned duties.

(3) Making available qualified clinical back up to cover vital daily UR activities during periods of time for scheduled or unscheduled leave, ensuring that there is no adverse impact on the business cycle process.

c. **Third-party Reviewers.** Third-party Reviewers are responsible for:

(1) Performing all UR activities, together with associated planning, developing, coordinating, implementing, and monitoring which include, but are not limited to:

(a) Prospective Reviews. Prospective reviews include: pre-admission and pre-certification for inpatient and/or outpatient services.

(b) Concurrent Reviews. Concurrent reviews include: Admission, continued-stay certification, and discharge review.

(c) Retrospective Reviews. Retrospective reviews include: retroactive-reimbursement reviews, denial management, appeals, and UR data analysis.

(2) Utilizing Claims Tracking to document all review results for communication to billing, accounts receivable, coding and other appropriate staff, and for data collection and reporting. Selected Claims Tracking UR report data with analysis will be provided, at least quarterly, or as often as UR staff considers necessary for focused improvement, to the Revenue Coordinator and as needed, to medical center management and appropriate committees.

(3) Serving as a patient advocate as well as program mediator providing accurate and timely clinical information to the insurance company. UR staff must acquire knowledge of insurance review criteria and must consult with physicians and providers, as necessary, for clinical assistance to ensure supporting documentation, and to establish collaboration for the exchange of complete and credible information between the insurance companies and the medical center.

(4) Conducting focused reviews for clinical input on a consultative basis. These review requests may include: sensitive diagnosis and/or special consent issues, service connected (SC) issues, tort feasor, workers compensation and Fee Service cases, requests for information, and other issues for the interpretation of clinical information. It is recognized that the volume of VA patients with reimbursable insurance may dictate the Full-time Equivalent (FTE) dedicated to third-party reimbursement; therefore, the UR staff needs to be flexible to assist in other Chief Business Office related clinical reviews.

(5) Establishing effective collaboration with the Revenue Coordinator and medical center staff to: identify problem areas, initiate corrective action, facilitate educational opportunities for multidisciplinary staff, and ensure an effective UR program for third-party reimbursement. UR staff must attend Chief Business Office conference calls and other educational opportunities applicable to UR activities.

(6) Ensuring program compliance with established review criteria for reimbursement and appeal of denials, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, VHA requirements, and confidentiality of medical record information. UR staff is to provide feedback, as appropriate, for patient case management, performance improvement, risk management, and compliance programs.

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: The VHA Chief Business Office (16) is responsible for the contents of this Directive. Questions should be addressed to 202-254-0362.

7. RESCISSION: None. This VHA Directive expires July 31, 2008.

S/ Louise Van Diepen for
Robert H. Roswell, M.D.
Under Secretary for Health

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